STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555388	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beach Creek Post-Acute	645 South Beach Blvd. Anaheim, CA 92804

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, medical record review, and facility P&P review, the facility failed to implement the comprehensive care plan for one of 27 final sampled residents (Resident 13). * Resident 13's At Risk for Respiratory Distress care plan showed to administer the oxygen as ordered by the physician (a rate of two liters per minute); however, Resident 13 was receiving oxygen at a rate of four and a half liters per minute. This failure posed the risk for not providing appropriate an individualized care to the resident. Findings: Review of the facility's P&P titled Oxygen Administration revised 6/5/23, showed the resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders such as, but not limited to: The type of oxygen delivery system, equipment setting for the prescribed flow rates, monitoring of oxygen saturation levels as ordered, and monitoring for complications associated with the use of oxygen. Medical record review for Resident 13 was initiated on 1/6/25. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's physician's orders showed an order dated 1/4/25, to administer a supplemental oxygen at a rate of two liters per minute, to keep Resident 13's oxygen saturation at 92% or greater. Review of Resident 13's plan of care showed a care plan titled At Risk for Respiratory Distress related to COPD and anxiety revised 12/9/24. The interventions showed to administer the oxygen as ordered. Resident 13's care plan goals showed Resident 13 would have no episodes of oxygen desaturation less than 90%. On 1/6/25 at 0833 hours, an observation, interview, and concurrent medical record review was conducted with LVN 8. Resident 13 was observed lying in bed with continuous oxygen being administered through an oxygen concentrator, at a rate of four and a half liters per minute via nasal cannula. However, Resident 13's care plan titled At Risk for Respiratory Distress related to COPD and anxiety revised 12/9/24, showed to administer oxygen as ordered by the physician (a rate of 2 liters per minute) and showed Resident 13 would have no episodes of oxygen desaturation less than 90%. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555388	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 8 lowered Resident 13's oxygen rate to two liters per minute (in accordance with the physician's order). LVN 8 then obtained Resident 13's oxygen saturation, which yielded a result of 86%. Cross reference to F695.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of two sampled residents (final sampled, Resident 13) reviewed for respiratory care, was provided with the appropriate respiratory care when: * The facility failed to follow the physician's order for the administration of continuous oxygen for Resident 13. This failure had the potential to result in negative health outcomes for the resident. Findings: Review of the facility's P&P titled Oxygen Administration revised 6/5/23, showed oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Oxygen is administered under orders of a physician. Medical record review for Resident 13 was initiated on 1/6/25. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's H&P examination dated 11/7/24, showed Resident 13 had a diagnosis of COPD. Review of Resident 13's physician's orders showed an order dated 1/4/25, to administer supplemental oxygen at a rate of two liters per minute, to keep Resident 13's oxygen saturation at 92% or greater. On 1/6/25 at 0750 hours, an observation was conducted of Resident 13. Resident 13 was observed lying in bed with continuous oxygen being administered through an oxygen concentrator, at a rate of four and a half liters per minute via nasal cannula. On 1/6/25 at 0833 hours, an observation, and concurrent interview was conducted with LVN 8. Resident 13 was observed lying in bed with continuous oxygen being administered through an oxygen concentrator, at a rate of four and a half liters per minute via nasal cannula. Resident 13 stated she received oxygen for shortness of breath. LVN 8 verified Resident 13 was receiving continuous oxygen at a rate of four and a half liters per minute, however, the physician's order showed to administer continuous oxygen at a rate of two liters per minute (to maintain Resident 13's oxygen saturation at 92% or greater). LVN 8 obtained Resident 13's oxygen saturation, while Resident 13 was receiving continuous oxygen at a rate of four and a half liters per minute, which yielded a result of 92%. LVN 8 then lowered Resident 13's oxygen rate to two liters per minute (as per the physician's order) and obtained Resident 13's oxygen saturation, which yielded a result of 86%. LVN 8 stated he would notify Resident 13's physician of Resident 13's change of condition (Resident 13's oxygen saturation of 86% on two liters per minute of continuous oxygen).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to attain and maintain the highest well-being for one of three residents (final sampled resident, Resident 106) reviewed for hemodialysis (treatment to remove waste and extra fluid from the blood using a filtering machine). * The facility failed to monitor Resident 106's fluid restriction as per the physician's order. This failure had the potential to negatively impact the resident's well-being. Findings: Review of the facility's P&P titled Fluid Intake and Output revised July 2017 showed the facility will monitor the intake and output as ordered by the physician. Maintaining intake and output for residents on restricted fluid diets, according to specific fluid restriction in the resident's plan of care. Medical record review for Resident 106 was initiated on 1/6/25. Resident 106 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 106's H&P examination dated 11/22/24, showed Resident 106 had a diagnosis of end stage renal disease (medical condition where the kidneys can no longer function properly) with dependence on hemodialysis. Review of Resident 106's Order Summary Report dated 1/8/25, showed the following physician's orders: - dated 11/27/24, to record the intake and output every shift; - dated 11/22/24, to monitor the LLE for edema; and - dated 11/22/24, to monitor the RLE for edema. Review of Resident 106's MAR dated January 2025, showed a physician's order for the fluid restriction of 1200 ml/24 hours related to the hemodialysis and included the following breakdown: - kitchen to provide 240 ml at breakfast; - kitchen to provide 240 ml at lunch; - kitchen to provide 240 ml at dinner; - nursing to provide 160 ml at AM shift; - nursing to provide 160 ml at PM shift; and (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- nursing to provide 160 ml at NOC shift. Review of Resident 106's Documentation Survey Report for CNAs for Fluid Intake dated January 2025, showed the following daily fluid intakes (fluids provided from the kitchen for breakfast, lunch and dinner) totals as follows: - 960 ml on 1/1/25 (more than the alloted total of 720 ml from all three meals); - 1120 ml on 1/2/25 (more than the alloted total of 720 ml from all three meals); - 680 ml on 1/3/25 (more than the alloted total of 720 ml from all three meals); - 980 ml on 1/4/25 (more than the alloted total of 720 ml from all three meals); - 960 ml on 1/5/25 (more than the alloted total of 720 ml from all three meals); and - 940 ml on 1/6/25 (more than the alloted total of 720 ml from all three meals). Review of Resident 106's MAR dated January 2025 showed Resident 106 had the following total daily fluid intakes (total for the fluid intake provided by the kitchen and nursing) as follows: - 950 ml on 1/1/25; - 1020 ml on 1/2/25; - 750 ml on 1/3/25; - 840 ml on 1/4/25; -1020 ml on 1/5/25; and - 780 ml on 1/6/25. Review of Resident 106's MAR dated January 2025, showed Resident 106 had edema on the following extremities on the following dates: - LLE on 1/2/25; - LLE on 1/3/25; - LLE on 1/4/25; - LLE on 1/5/25; - RLE on 1/2/25; - RLE on 1/3/25; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- RLE on 1/4/25; and - RLE on 1/5/25. On 1/9/25 at 1318 hours, an interview and concurrent medical record review was conducted with LVN 6. LVN 6 acknowledged and verified the above findings. LVN 6 stated the CNAs document the resident's fluid intake from the meals on the Documentation Survey Report for CNAs for Fluid Intake. On 1/9/25 at 1408 hours, an interview and concurrent medical record review was conducted with the DON. The DON acknowledged and verified the above findings. The DON stated the CNAs were documenting the resident's fluid intake on the Documentation Survey Report for CNAs for Fluid Intake in regards to the fluid consumed by the resident from the water pitcher at bedside, nourishments and the fluids served with the meals. The DON further stated the licensed nurses were expected to collaborate with the CNAs to calculate the resident's total intake, including the fluid intake alloted for nursing per the physician's order. The DON verified the inconsistency of the documentation of the resident's intake from the MAR by the licensed nurses and Documentaion Survey Report by the CNA.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the pharmacy services as per the facility P&P for four nonsampled residents (Residents 63, 77, 85, and 118). * LVN 6 failed to ensure Residents 63 and 77's scheduled morning medications (at 0900 hours) were administered timely within 60 minutes of the scheduled time. * The facility failed to ensure the accurate and complete documentation of the controlled medications administered to Resident 85. * The facility failed to ensure the administration of the controlled medication for Resident 118 was documented in the narcotic and hypnotic record. These failures had the potential to place the residents at risk for delays in treatment and increased risk for adverse events and posed the risk for diversion of medications. Findings: 1. Review of the facility's P&P titled Medication Administration revised 12/19/22, showed to administer resident's medications within 60 minutes prior to or after scheduled time, unless otherwise ordered by the physician. On 1/8/25 at 1030 hours, an observation and concurrent interview was conducted with LVN 6. LVN 6 was observed administering medications to the facility residents. Residents 63 and 77 had yet to receive their morning medications (scheduled for 0900 hours). LVN 6 verified Residents 63 and 77 had yet to receive their scheduled morning medications (at 0900 hours). LVN 6 stated the medications were to be administered within 60 minutes of the scheduled time. a. Review of Resident 63's Order Summary Report dated 1/2025, showed the following medications were ordered to be administered on 1/8/25, at 0900 hours: - Apixaban (anticoagulant) 2.5 mg tablet orally two times a day for DVT. - Megestrol acetate (hormonal drug therapy used as an appetite stimulant) 40 mg tablet orally one time a day for appetite stimulant. - Multi-vitamin/minerals one tablet orally for supplement. - Oxybutynin (bladder relaxant) 15 mg extended-release tablet orally for overactive bladder. - Potassium chloride 20 meq extended-release tablet orally for supplement. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

b. Review of Resident 77's Order Summary Report dated 1/2025, showed the following medications were ordered to be administered on 1/8/25, at 0900 hours:

- Lisinopril (antihypertensive)10 mg tablet orally in the morning for hypertension (high blood pressure).

- Metoprolol (antihypertensive) 25 mg tablet orally two times a day for hypertension.

- Norco (analgesic) 5-325 mg tablet orally every 12 hours for pain management.

- Pioglitazone (anti-diabetic medication) 30 mg tablet orally in the morning for diabetes (high blood sugar).

- Calcium 600 mg tablet orally two times a day supplement.

- Cymbalta (medication to treat nerve pain) 60 mg delayed release capsule once a day for neuropathy (weakness, numbness, and pain from nerve damage).

- Docusate sodium (laxative) 200 mg orally once a day for bowel management.

- Donepezil (cognitive enhancer) 15 mg orally once a day for dementia (medical condition affecting a person's ability to think, remember and behave).

- Senokot (laxative) 8.6 mg (two tablets) orally in the morning for bowel management.

- Vitamin D3 125 microgram tablet orally in the morning supplement.

- Multivitamin/mineral one tablet orally for supplement.

45064

2. Review of the facility's P&P titled Administering Oral Medications revised 10/2010 showed the facility shall maintain a medication administration record to document all medications administered.

a. Medical record review for Resident 85 was initiated on 1/7/25. Resident 85 was admitted to the facility on [DATE], and readmitted on [DATE].

Review of Resident's 85 H&P examination dated 3/20/24, showed Resident 85 had the capacity to understand and make decisions.

Review of Resident 85's Order Summary Report dated 1/7/25, showed a physician's order date 5/29/24, to administer oxycodone-acetaminophen (controlled pain medication) 10-325 mg one tablet by mouth every four hours as needed for severe pain (pain level of 5-10, using the 0-10 pain scale; zero meaning no pain and 10 meaning worst pain).

Review of Resident 85's Narcotic and Hypnotic Record showed the oxycodone-acetaminophen 10-325 mg oral tablet was dispensed and signed out on 11/29/24 at 1300 hours.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 85's November 2024 MAR failed to show the documentation of the administration for the oxycodone-acetaminophen medication on 11/29/24 at 1300 hours. On 1/7/25 at 1111 hours, an interview and concurrent medical record review was conducted with LVN 9. LVN 9 verified the above findings. On 1/7/25 at 1510 hours, an interview and concurrent medical record review was conducted with the DON. The DON was informed and verified the above findings. The DON stated the licensed nurse needed to document on the MAR when the medication was administered to the resident. 50967 b. Medical record review for Resident 118 was initiated on 1/7/25. Resident 118 was admitted to the facility on [DATE]. Review of Resident 118's H&P examination dated 7/3/24, showed Resident 118 had the capacity to understand and make decisions. Review of Resident 118's Order Summary Report showed a physician's order dated 7/2/24, to administer buprenorphine HCI (schedule III narcotic analgesic medication to treat opioid or narcotic dependence or addiction) 8 mg one tablet sublingually (under the tongue) in the morning for opioid use disorder. On 1/7/25 at 1035 hours, a controlled medication count review for Resident 118 was conducted with the TRC DON and LVN 2. Review of 118's buprenorphine HCI sublingual tablet 8 mg Narcotic and Hypnotic Record showed the medication was given routinely in the morning at 0700 hours. However, review of Resident 118's Narcotic and Hypnotic Record for the buprenorphine HCI medication did not show the documentation the medication was signed out on 1/5/25 at 0700 hours. The TRC DON verified the above finding. TRC DON stated he would investigate who was assigned on 1/5/25. LVN 2 checked Resident 118's MAR and stated LVN 3 administered the medication. The TRC DON stated the protocol for administering a narcotic or controlled medication was to pour, pass, and sign the narcotic record sheet then the MAR. On 1/8/25 at 1051 hours, an interview was conducted with LVN 3. LVN 3 verified she worked on 1/5/25 and was assigned to administer the medication to Resident 118 at 0700 hours. LVN 3 stated she recalled administering the buprenorphine medication to Resident 118 but did not document in the Narcotic and Hypnotic Record sheet after administering the medication. LVN 3 stated she was supposed to document in the Narcotic and Hypnotic Record sheet right after administering the medication. On 1/9/25 1437 at hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 8.33%. * Resident 4 had a physician's order for vitamin B12 5000 micrograms orally to be administered one time a day for supplement; however, the LVN administered vitamin B12 1000 micrograms to Resident 4. In addition, the LVN applied a nicotine 21 mg transdermal patch to Resident 4's lower back; however, Resident 4 did not have a physician's order for a nicotine transdermal patch. * Resident 63 had a physician's order for a multi-vitamin/minerals tablet to be administered orally for supplement; however, the LVN administered a multi-vitamin without minerals to Resident 63. These failures had the potential to negatively affect the residents' health. Findings: Review of the facility's P&P titled Medication Administration revised 12/19/22, showed medications are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice. 1. Medical record for Resident 4 was initiated on 1/6/25. Resident 4 was admitted to the facility on [DATE]. On 1/8/25 at 0839 hours, a medication administration observation for Resident 4 was conducted with LVN 10. LVN 10 prepared and administered Resident 4's medications. During the medication administration for Resident 4, LVN 10 was observed having applied a nicotine 21 mg transdermal patch to Resident 4's lower back. LVN 10 was also observed having administered vitamin B12 1000 micrograms orally to Resident 4. Review of Resident 4's physician's orders showed an order dated 12/4/24, to administer vitamin B12 5000 micrograms orally one time a day for supplement. Further review of Resident 4's active physician's orders failed to show Resident 4 had an order for a nicotine 21 mg transdermal patch. On 1/8/25 at 0946 hours, an interview and concurrent medical record review was conducted with LVN 10. LVN 10 reviewed Resident 4's active physician's orders. LVN 10 verified Resident 4's physician's order showed to administer vitamin B 12 5000 micrograms orally, however, LVN 10 administered vitamin B 12 1000 micrograms orally. LVN 10 also verified Resident 4 did not have an order for a nicotine 21 mg transdermal patch. 2. Medical record review for Resident 63 was initiated on 1/6/25. Resident 63 was admitted to the facility on [DATE]. On 1/8/25 at 1030 hours, a medication administration observation for Resident 63 was conducted with LVN 6. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the medication administration for Resident 63, LVN 6 was observed having administered a multi-vitamin tablet orally to Resident 63. Review of Resident 63's physician's orders showed an order dated 1/20/24, to administer multi-vitamin/minerals tablet orally in the morning for supplement. LVN 6 verified she administered a multi-vitamin tablet to Resident 63, however, the physician's order showed to administer a multi-vitamin with minerals tablet.

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F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50967

Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure proper storage, labeling, and disposal of medications.

* The facility failed to ensure the orally administered medications were stored separately from the rectally administered medication in Medication Cart 5.

* The facility failed to ensure the medication drawer was kept clean and free of dried white residue in Medication Cart 5.

* A package which contained nicotine 21 mg transdermal patches was not labeled with a resident's name, prescribing physician's name, prescription number, or prescribed dose. Subsequently a LVN applied the nicotine 21 mg transdermal patch to a resident (Resident 4) without a physician's order for the nicotine 21 mg transdermal patch.

* Resident 63's carvedilol (antihypertensive medication) medication order and carvedilol medication packaging had conflicting hold parameters specific to the systolic blood pressure monitoring.

These failures had the potential to negatively impact the residents' well-being, and the potential for the medications to lose the stability and effectiveness.

Findings:

Review of the facility's P&P titled Medication Storage in the Facility revised on 1/2018 showed the following:

- Orally administered medications are kept separate from externally used medications and treatments such as suppositories, ointments, creams, vaginal products, and etc; and

- Medication storage areas are kept clean, well-lit, free of clutter, extreme temperatures and humidity.

1. On 1/7/25 at 1110 hours, a medication cart inspection for Medication Cart 5 was conducted with the TRC DON. The following was observed:

- a bottle of Mylanta (used to treat stomach upset, heart burn, and acid indigestion) and a bottle of Milk of Magnesia (MOM) (used to treat constipation) were stored with a box of bisacodyl (used to treat occasional constipation) suppository.

- dried white residue on side of the drawer where the Mylanta and MOM were stored and under the bottles of Mylanta and MOM.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The TRC DON verified the above findings. On 1/8/25 at 1500 hours, an interview was conducted with the DON. The DON stated the oral and rectal medications should be stored separately and not mixed in the same storage. The DON was informed and acknowledged the above findings. 37726 2. Review of the facility's P&P titled Labeling of Medications and Biologicals revised 12/19/22, showed labels for individual drug containers must include the resident's name, prescribing physician's name, prescription number, prescribed dose, and the appropriate instructions and precautions. Medical record for Resident 4 was initiated on 1/6/25. Resident 4 was admitted to the facility on [DATE]. On 1/8/25 at 0839 hours, a medication administration observation for Resident 4 was conducted with LVN 10. LVN 10 prepared and administered Resident 4's medications. During the medication administration for Resident 4, LVN 10 was observed having applied a nicotine 21 mg transdermal patch to Resident 4's lower back. On 1/8/25 at 0946 hours, an interview and concurrent medical record review was conducted with LVN 10. LVN 10 reviewed Resident 4's active physician's orders. LVN 10 verified Resident 4 did not have an order for a nicotine 21 mg transdermal patch. The package which contained the nicotine 21 mg transdermal patches was observed without a label. The label had been pealed from the box. The package which contained the nicotine 21 mg transdermal patches was not labeled with a resident's name, prescribing physician's name, prescription number, prescribed dose, or the appropriate instructions and precautions. LVN 10 verified the findings. LVN 10 stated the label should include a resident's name to identify which resident to apply the nicotine patch. Cross reference to F759, example #1. 3. Medical record review for Resident 63 was initiated on 1/6/25. Resident 63 was admitted to the facility on [DATE]. On 1/8/25 at 1030 hours, a medication administration observation for Resident 63 was conducted with LVN 6. During the medication administration for Resident 63, LVN 6 was observed having held Resident 63's scheduled morning (0900 hours) carvedilol (antihypertensive medication) 3.125 mg tablet. LVN 6 stated Resident 63's systolic blood pressure was 101 and the physician's order showed to hold the medication if Resident 63's systolic blood pressure was less than 110. The bubble pack (packaging) which contained the carvedilol 3.125 mg tablets showed instructions to hold the medication if Resident 63's systolic blood pressure was less than 100. LVN 6 verified the findings and stated she needed to clarify the discrepancy specific to the hold parameters for the medication.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45064 Based on observation, interview, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen when: * The facility failed to ensure the ice machine was maintained in a sanitary condition. * The facility failed to ensure the raw meat was stored in a sanitary manner. * The facility failed to ensure the kitchen equipment was clean. These failures posed the risk for food borne illnesses in highly susceptible resident population of 125 facility residents who received food prepared in the kitchen. Findings: Review of the CMS 672 Resident Census and Conditions of Residents completed by the facility dated 1/6/25, showed 125 of 134 residents in the facility received food prepared in the kitchen. 1. According to the USDA Food Code 2022, Section 4-601.11 Equipment, Food- Contact Surfaces, Nonfood Contact Surfaces, and Utensils. (A) Equipment, food-contact surfaces and utensils shall be clean to sight and touch. Review of the facility's P&P titled Food Safety and Food Storage revised on 11/4/24, showed cleaning and sanitizing the internal component of the ice machine according to manufacturer's guidelines. On 1/6/25 at 0840 hours, an observation and concurrent interview was conducted with the MS for Ice Machine 1. Ice Machine 1's trough (a long container that hold water used to make ice) was observed with approximately half a cup of an unknown white powder substance floating in the water. When touched, the white powder substance was soft, swirled around in the water and did not dissolve. The MS verified the finding and stated it was hard water deposit. On 1/6/26 at 1059 hours, a follow up interview was conducted with the MS. The MS stated he adjusted Ice Machine 1 because it was not draining properly. The MS stated the white powder substance in the ice machine's trough was chlorine from the water. When asked again what the white powder substance was, the MS stated, I don't know. The MS stated he noticed the white powder substance on 12/27/24, when the ice machine was cleaned. The MS stated the unknown white powder substance accumulated more since the ice machine was cleaned. 2. A review of US Food and Drug Administration titled Food Ingredients and Packaging dated 7/6/23, showed the FDA regulates the safety of ingredients added directly to food and substances that come into contact with food, such as those added to packaging materials, cookware of containers that store food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/6/25 at 0800 hours, an observation of Freezer 1 was conducted with the DSS. More than six pieces of raw beef chuck were stored inside plastic grocery bags. On 1/6/25 at 1112 hours, a follow up interview was conducted with the DSS. The DSS stated, the plastic bags used to store the beef chuck were grocery bags purchased from the purveyor. The DSS verified the grocery bags were not approved for food storage. 3. According to the USDA Food Code 2022, Section 4-601.11 Equipment, Food- Contact Surfaces, Nonfood Contact Surfaces, and Utensils. (A) Equipment, food-contact surfaces and utensils shall be clean to sight and touch. On 1/6/25 at 0800 hours, an observation and concurrent interview was conducted with the DSS. One of three residents' meal tray drying rack was observed with a brown residue, which resembled rust and had peeling paint. The DSS verified the finding and stated he will order a new rack today.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. 45064 Based on observation, interview, and facility P&P review, the facility failed to dispose and store trash in a sanitary manner. This failure posed the threat for pest contamination. Findings: According to the US Food Code 2022, Section 5-501.113, Covering Receptacles, receptacle units for refuse shall be kept covered with tight fitting lids after they are filled. Review of the facility's P&P titled Dispose of Garbage and Refuse reviewed/revised 12/19/22, showed the refuse containers and dumpsters kept outside the facility shall be designed and constructed to have tightly fitting lids, doors, or covers. On 1/6/25 at 0926 hours, an observation of trash disposal with DSS was conducted. Two of three dumpsters were observed located outside of the facility with lids not completely close. The DSS stated one of the dumpster lid was bent, and the other dumpster had too much trash in it. The DSS verified the trash was exposed, and the lids of the two dumpsters were not fully closed.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 46787 Based on interview and facility document review, the facility failed to conduct and document a facility-wide assessment to determine the resources necessary to care for its residents competently during both day-to-day operations and emergencies. This failure posed the risk of the facility not being able to evaluate its resident population and identify the resources needed to provide the necessary care and services the residents required. Findings: On 1/6/25 at 0830 hours, an entrance conference was conducted with the Administrator and DON. When the Entrance Conference Worksheet items needed within four hours were read, the Facility Assessment was requested. On 1/6/25 at 1600 hours, an interview was conducted with the Administrator. The Administrator stated the Facility Assessment had not been completed. On 1/7/25 at 0730 hours, the Administrator submitted a Facility Assessment to the survey team.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of nonsampled resident (Resident 51) had accurate and complete medical records. * The facility failed to ensure Resident 51's Pulmonary administration were documented as ordered. This failure had the potential for the resident's health care needs to not be met as the medical record was incomplete and inaccurate. Findings: Review of the facility's P&P titled Documentation in Medical Record dated 10/2022 showed the following: - Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with the state law and facility policy; and - Documentation can be completed at the time of service, but no later than the shift which the assessment, observation, or care service occurred. Medical record review for Resident 51 was initiated on 1/8/25. Resident 51 was admitted to the facility on [DATE]. On 1/6/25 at 1301 hours, Resident 51 was observed using the oxygen via nasal cannula during lunch time. Resident 51 stated I used the oxygen when I'm short winded and during the ambulation. LVN 7 verified the above findings. Review of Resident 51's Order Summary Report showed the following physician's orders: - dated 9/18/24, to administer Anoro Ellipta (used to help relieve symptoms of COPD) inhalation, one inhalation orally one time a day for COPD; - dated 9/24/224, to clean the outside of the devices and flow head with 70% isopropyl alcohol impregnated cloth to remove any visible soiling for low level disinfection before and after each patient use every shift for COPD; - dated 9/24/24, Pulmonary: demonstration and/or evaluation of respiratory treatment (assessment and treatment) every shift related to COPD; (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	- dated 9/24/24, Pulmonary: Incentive spirometer treatments to sit up straight, breathe out normally. Place mouthpiece in the mouth, seal the lips around the mouthpiece, breath in slowly and deeply with lips sealed tightly around the mouthpiece. Inhale deeply, hold your breath for at least three seconds, remove mouthpiece and breathe out normally, repeat times 10 as needed three times a day every Tuesday, Wednesday, Thursday, Friday, and Saturday for prolonged bedrest/prevent pneumonia and development of atelectasis (medical condition when part or all of the lung collapses); - dated 11/26/24, Pulmonary: chest physiotherapy via Acapella three times a day every Tuesday, Wednesday, Thursday, Friday, and Saturday for enhance pulmonary function and mucociliary airway clearance related to COPD; and - dated 1/6/25, to administer the oxygen at two liters per minute via nasal cannula. May titrate up to five liters via nasal cannula as needed to maintain oxygen saturation between 88-92 % for shortness of breath related to COPD. On 1/8/25 at 1210 hours, a concurrent interview and medical record review was conducted with LVN 5. Resident 51's Pulmonary administration record for January 2025 was reviewed with LVN 5. LVN 5 verified the missing initials by the licensed nurses to show for the administration of the above physician's orders for Resident 51 on the following dates: - 1/3/24, for incentive spirometer treatment; - 1/3/24, for chest physiotherapy via Acapella; - 1/3-1/6/25, to clean outside surface of devices; - 1/5-1/6/25 at 0900 hours, to administer Anoro Ellipta Inhalation 1 inhalation inhale orally one time a day for COPD; - 1/5-1/6/25, for pulmonary demonstration; and - 1/6/25, for the administration of oxygen at two liters per minute via nasal cannula as needed. On 1/8/25 at 1500 hours, an interview was conducted with the DON. The DON was asked regarding the documentation after administration of the medication and ordered monitoring or assessment. The DON stated the licensed facility staff must document or chart after the administration of the medications and completing any assessments or pulmonary treatments before the shift ended. On 1/9/25 1437 at hours, the DON and Administrator were informed and acknowledged the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51920 Based on observation, interview, medical record review, and facility P&P review, the facility failed to maintain the infection prevention and control practices to help prevent the development and transmission of communicable diseases and infections when: * CNA 1 did not follow the EBP when providing incontinence care for Resident 58. * The facility failed to ensure the CNA donned the appropriate PPE when providing care to Resident 50. * There was no receptacle readily available to discard used gowns for the resident on EBP. These failures had the potential to spread infection in the facility. Findings: Review of the facility's P&P titled Infection Control revised October 2018 showed the facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. The objectives of our infection control practices are to: Prevent, detect, investigate, and control infections in the facility and establish guidelines for implementing Isolation Precautions, including Standard and Transmission-Based Precautions. On 1/6/25 at 0825 hours, an EBP sign was observed outside of Resident 58's room. The EBP sign showed everyone must wear gloves and a gown for high-contact resident care activities for Resident 58. The PPE cart was observed hanging on the door and was fully stocked. CNA 1 was observed changing Resident 58's incontinence brief while wearing gloves; however, CNA 1 was observed without a gown. Review of CNA 1's Certified Nursing Assistant Competench Checklist dated 8/21/24, showed CNA 1 was competent in the following training categories for the Infection Control: - Standard Precautions; including application and removal of PPE and location of PPE; and - Enhanced Isolations, Contact, Droplet, Airborne. On 1/6/25 at 1457 hours, an interview was conducted with CNA 1. CNA 1 verified she did not don a gown while providing incontinence care to Resident 58 and stated it was an accident. On 1/8/25 at 0840 hous, an interview was conducted with the IP. The IP stated she provided ongoing education on EBP to the facility staff members. The IP was informed and acknowledge the finding. 37726 2. Medical record review for Resident 50 was initiated on 1/6/25. Resident 50 was admitted to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 50's physician's order dated 6/7/24, showed an order for enhanced barrier precautions for a diagnosis of GT (a small tube placed through the abdominal wall into the stomach, used to provide feeding formula and/or administer medications). Review of Resident 50's care plan titled Enhanced Barrier Precautions (GT) revised 6/7/24, showed to practice isolation precautions for infection control and to follow infection control procedure. On 1/7/25 at 1622 hours, an observation and concurrent interview was conducted with CNA 6. At the entrance to Resident 50's room, a sign was posted which showed enhanced barrier precautions were required. The sign showed providers must wear gloves and a gown when bathing and changing Resident 50. Resident 50 was observed inside of her room lying on her bed. CNA 6 was observed providing care to Resident 50. CNA 6 was observed bathing and changing Resident 50's adult brief. CNA 6 was observed only wearing gloves while providing care to Resident 50, however, CNA 6 failed to don a gown while she was bathing and changing Resident 50's adult brief. CNA 6 verified in accordance with the ordered enhanced barrier precautions, she should have donned a gown while bathing and changing Resident 50, for infection control. On 1/7/25 at 1642 hours, an interview was conducted with the IP. The IP verified in accordance with the EBP, the staff members were required to don gloves and a gown while bathing and changing Resident 50's adult brief, for infection control. 35346 3. On 01/07/25 at 1028 hours, during the initial observation of Room A, there was no receptacle to dispose of the used gowns readily available. Room A was designated as an enhanced barrier precautions room. When asked about any receptacle readily available to dispose of the used gowns, LVN 1 initially was unable to explain, but then stated the used gown would be placed in a bin located outside Room A, approximately 15 feet away.